brought your fingers with you, for I shall put them on again.' The man objected much to this, and for some time obstinately refused to submit to such 'foolish nonsense;' however, I succeeded in carrying my point, and the severed fingers were replaced on the wounds. The result was satisfactory; perfect union was established.

"About three weeks since, William Clare, of this town, publican, came to my surgery, having severed the ring finger of the left hand by a chaff-machine, immediately below the nail, cutting through the phalanx. He was followed by his son, who had discovered the finger amongst the chaff. I carefully replaced it, and treated it in the same way as the preceding cases. At the end of ten days, union was perfect. The nail sloughed off, and a new one is rapidly forming.

"I record these few cases out of many, to show what may be done by the plastic principle of adhesive inflammation even in the restoration of parts which have been separated from the living body, and usually regarded as incapable of reanimation; and also to press upon my brethren never to lose sight of the chance of trying the effects of human grafting, especially in joints like the fingers, where the measure of vital energy required for reanimation is so small.

"For my own part, I have not had a single instance of failure in a somewhat extended practice, when I have had to deal with these kind of amputations occurring in the first or second phalanx."

37. *Spontaneous Dislocation of the Femur.*—In bringing this subject before the Vienna Medical Society, Dr. Dittl adverted to the differences which existed between traumatic and spontaneous luxation. In the former, the result of great violence to a healthy subject, the *ligamentum teres* and the capsule are always torn, the head of the bone lying external to the ruptured capsule. According to the author's numerous experiments and his examination of specimens, this laceration of the capsule does not take place as a mere slit, it always becoming at the same time partially separated from its insertion in the edge of the acetabulum, forming a triangular flap, which by interposition may render reduction difficult. Spontaneous luxation, on the other hand, is always the consequence of a disease, and occurs through mere muscular action, unaccompanied by external violence. Any disease, as soft enchondroma, gelatinous cancer, etc., but most commonly inflammation, which leads to a loosening of the texture of the surrounding tissues, may give rise to the displacement. These being soaked in exsudative matters, the cartilage softens, so that a plate of it and the ligamentum teres may be defibrinated by means of a forcep. The capsule becoming swollen, passively yielding, and distended like a bladder. The patient usually remains upon his back, with the hip-joint bent, the head of the bone pressing upon the posterior edge of the acetabulum, in which direction it is also forced by the muscles acting through reflected contraction. For this reason the edge of the acetabulum and the corresponding portion of the head of the bone undergo diminution, and the occurrence of luxation is favoured; and, if arrest of the disease could now be obtained, the head of the bone would no longer enter the cavity completely. Contrary to what takes place in traumatic luxation, the ligamentum teres in this form of dislocation is not necessarily torn, and the capsule is uninjured and still retains the head within its cavity.

For the prognosis, the determination of the stage of the disease at which the luxation takes place is of great importance. At an early period, reposition is more difficult, but the result is more durable; while later, the head is easily replaced and easily resumes its abnormal position. In caries no attempt at replacement should be made. Reposition is contraindicated when the muscles have become firmly contracted, owing to the position they have retained, when abundant osteophites have become developed and when inflammatory action is still present. Dr. Dittl thinks that direct extension should not be employed for the purpose of obtaining reposition; and, in the two cases which came under his own care, applying the hand to the knee, he bent the limb strongly forward, loosening the head of the bone from its adhesions by movements of abduction and adduction, and rotating it outwards during abduction. The after-treatment is of the highest consequence, as, if neglected, relapse may easily occur. It consists in keeping the thigh, by means of bandages, extended and rotated o

wards for one or two months. Some amount of shortening will remain after recovery, as also some eversion of the foot. In one of the author's cases, reduction took place five months after the occurrence of the luxation, and six months later the patient was able to get about unassisted. In the other case six months had elapsed before reduction was effected. Passive movements of the limb executed four weeks afterwards, re-excited inflammatory action, which, however, was soon abated. The reduction should be accomplished under the influence of chloroform, in consequence of the active contraction of the muscles attempts at effecting it excite. Dr. Salzer, founding his remarks on a case which occurred in Heyfelder's practice, disagreed with the author in thinking it necessary to await the subsidence of inflammation before proceeding to reduction; on the contrary, this should be effected as soon after the occurrence of the luxation as possible, as delay renders it difficult or impossible, while after its completion the inflammation subsides. The subject of the case alluded to was a medical practitioner, who was able to leave his bed four weeks after the reduction, and is now in the active pursuit of his profession.—*Med. Times and Gaz.*, Jan. 11, 1862, from *Wochenblatt der Gesell. der Aerzte in Wien*, No. 26.

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38. *On the Treatment of Aneurism of the Extremities by Flexion of the Limb.*—Mr. ERNEST HART, in a paper read before the Royal Medical and Chirurgical Society, in April, 1859 (see number of this Journal for July, 1859, p. 242), brought to the notice of the society a case of popliteal aneurism, which he had successfully treated by flexion of the leg in 1858. Mr. A. Shaw kindly communicated at the same time a second case, which he had subsequently successfully treated by that method. Mr. Hart wished to ask the attention of the society to some further cases treated with success on this plan since the above were made public through the medium of the *Transactions*. They were all cases of aneurism of the extremities—for the most part popliteal. Indeed, by the nature of this method of treatment, its application was confined to the extremities; for here the general law of position of the great arteries to some extent favoured it. The author remarked that the effect of forcible flexion of the healthy arm or leg might be observed in the considerable retardation of the blood flowing through the main artery, and the almost entire extinction of its pulse. The application of this principle to the extreme flexion of the arterial trunks was obvious. Their structure favoured the effect described. Probably, also, the projecting bellies of the contracted muscles might cause some pressure on an artery which lay in contact with them; and in the case of an aneurismal swelling some direct pressure might be made upon the tumour; but of the occurrence of this circumstance, or of its desirability, the author was doubtful. It was now pretty clearly established and generally accepted, that the object in treating aneurism was not to cut off the supply of blood, or altogether at once to arrest circulation in it, but to cause such a retardation of the current as would lead to the gradual deposit of fibrinous laminæ in the interior, and so effect its gradual consolidation. The former method was uncertain and dangerous; the latter safe and permanent in its results. In the case in which the author first applied the method of flexion to the treatment of popliteal aneurism, and in that in which Mr. Shaw subsequently tested it, they were completely successful in obtaining the latter result. Mr. Hart had met with similar success in the following case:—

CASE 3. In September, 1860, a healthy and robust looking man, aged thirty-five, was sent to him by Mr. Bridge, for treatment of a popliteal aneurism of the left leg. It was of the size and shape of a large lemon, projecting on the inner side of the ham. It had a loud bruit and very perceptible thrill, but was not entirely reducible. The skin was somewhat discoloured over the tumour, as though from a recent bruise. The patient had noticed the existence of this pulsating tumour for nearly two years. It had increased somewhat in size during the first nine months that he had observed it, and he had several times thought of seeking advice, but as he had felt little pain from the disease, he had neglected its cure. About three weeks before the author saw him, he had received a blow in the region of the tumour, and since then he had suffered pain in it, and the swelling had increased. The arteries of the leg pulsated distinctly, and there was no very marked dilatation of the veins below the knee. There